Health Check/EPSDT
May 2008 Seminar Registration Form
(No Fee)

Provider Name_____

Medicaid Provider Number_____ NPI Number_____

Mailing Address_____

City, Zip Code_____County_____

Contact Person_____E-mail_____

Telephone Number(____)_____Fax Number_____

1 or **2** person(s) will attend the seminar at _____on_____
(circle one) (location) (date)

Please fax completed form to: 919-851-4014

Please mail completed form to:
EDS Provider Services
P.O. Box 300009
Raleigh, NC 27622